S45. Eating disorders: epidemiology, course and risk factors

Chairs: M. Fichter (D), W. Vandereycken (B)

S45.01

EPIDEMIOLOGY OF EATING DISORDERS

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To examine the incidence and prevalence of eating disorders, we used several data sources. The prevalence rates in the population are derived from a meta analysis of two-stage studies in the young female population.[1] The incidence of eating disorders in primary care has been examined by a Dutch nationwide network of primary care physicians in 1985–1989[2] and 1995–1999. By examining medical records and psychiatric case registers we studied the epidemiology in (mental) health care in Curaçao[3] and the Netherlands.

The one year prevalence among young females in the general population is 0.4% for anorexia nervosa and 1.5% for bulimia nervosa. Only small percentages of patients with eating disorders are detected in primary care and referred to mental health care. The registered incidence rates for anorexia nervosa have increased sharply till the 1970's, but has been rather stable afterwards. Because bulimia nervosa has only been distinguished as a separate disorder after 1980, it is difficult to examine trends in the incidence of bulimia nervosa. The incidence of anorexia nervosa is around 8 per 100,000 in primary care and 5 per 100,000 in mental health care in the 1980's and 1990's. The incidence of bulimia nervosa is around 12 per 100,000 population in primary care and 6 per 100,000 in mental health care.

Results from the Curaçao study challenge the hypothesis that anorexia nervosa is a western culture bound syndrome occurring mainly in white women.

(1) Hoeken D van, et al. Epidemiology. In: Hoek HW, Treasure JL, Katzman MA (eds). Neurobiology in the Treatment of Eating Disorders. John Wiley & Sons, 1998: 97–126;
(2) Hoek HW, et al. Am J Psychiatry 1995; 152: 1272–8;
(3) Hoek HW, et al. New Engl J Med 1998; 338 (17): 1231–2.

S45.02

THE COURSE OF EATING DISORDERS (AN, BN, BED): PREDICTORS, RISK FACTORS AND CAUSAL MODELS

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No abstract was available at the time of printing.

S45.03

EMOTIONAL MODELS IN EATING DISORDERS

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The aim of this talk is to present evidence from various studies on emotional processing in anorexia nervosa. Patients with eating disorders show high levels of disgust sensitivity when tested using standard questionnaire measures. The recognition of facial emotions in self and others is attenuated but disgust is relatively spared. Patient with anorexia nervosa perceive food to be frightening and disgusting and they experience psychophysiological arousal when presented with food. In addition they show abnormal brain activation to food stimuli with MRI scanning. The brain areas activated by food related stimuli are close to areas activated by negative emotions, severely aversive smells, tastes and hunger. In conclusion, several aspects of emotional functioning are abnormal in anorexia nervosa. It appears that food, a rewarding stimuli, may be processed as if it is aversive and that this may be part of a more general aspect of emotional dysfunction.

S45.04

BODY IMAGE IN EATING DISORDERS

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Common features in Eating disorders are the importance of physical appearance and the great fear of becoming fat. Most of studies were using various body size estimation techniques and the results were clearly contradictories. Beside the methodological problems involved in this type of research, few studies have been done about the impact of therapy on body image. The purpose of the current study was to determine the efficacy of a cognitive-behavioral (CBT) outpatient treatment in Eating Disorders, using a video-confrontation (VC) procedure.

Method: 120 patients diagnosed, according to the DSM-IV criteria, of Anorexia (AN, N = 60) or Bulimia nervosa (BN, N = 60), and who were consecutively treated in our Unit. All were female. The whole patients were randomly assigned to two different therapeutical approaches: (1) Experimental Group, EG (CBT + VC) or (2) Control group, CG (only CBT). Prior, after the treatment and at one-year follow-up several clinical and psychometrical measures were used for the assessment.

Results: Outpatient group therapy (CBT) was effective as well in AN as in BN (60–80% of cases). When compared improvements in EG vs. CG, there were not significant differences concerning this factor ($p > .05$). Poor outcome was predicted by the following measures made at the time of admission: greater severity of illness, more frequent vomiting ($p < .02$) and premorbid obesity ($p < .04$).

Conclusions: There was no evidence for a major efficacy of CBT when VC procedures were additionally used in the outpatient treatment of eating disorders. Therapeutical implications of such a body-oriented therapy as well as the relevance of the construct body image will be discussed.

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S45.05

BODY IMAGE DISTURBANCES IN OBESITY BEFORE AND AFTER WEIGHT LOSS

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Background: Many overweight persons have a negative body image: persistent preoccupation with the physical aspect that causes enduring distress and serious interference with personal functioning. Obese binge eaters *(O-BED)* present more serious body image disturbances than obese non binge eaters *(O-non-BED)*. Body image dissatisfaction is the most common reported motivation for losing weight but body image change has been virtually ignored in obesity treatment outcome studies.

Objective: The purpose of this study was to explore the effects of weight loss on body image in a sample of obese subjects six and twelve months after bariatric surgery.

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Design: We studied 107 consecutive bariatric surgery candidates immediately before and six and twelve months after the operation (adjustable gastric band). All participants completed the Eating Disorder Examination (EDE 12.0D, Fairburn and Cooper, 1993), the Body Dysmorphic Disorder Examination (BDDE, Rosen and Reiter, 1994), the Binge Eating Scale (BES, Gormally *et al.*, 1982), the Shame and Guilt Susceptibility Scale (SSCV, Battacchi *et al.*, 1998) and the Body Uneasiness Test (BUT, Cuzzolaro *et al.*, 1999). EDE 12.0D and BES were used to evaluate binge behavior and to support the diagnosis of *BED*. BDDE was used to exclude a double diagnosis of *BED* and body dysmorphic disorder and to assess negative body image through a semistructured interview, SSCV evaluates guilt and shame emotions on eleven subscales. The BUT is a new self-report questionnaire: higher scores (Global Severity Index) indicate greater body uneasiness. BUT provides moreover scores on five subscales: *Weight Phobia, Body Image Concerns, Avoidance, Compulsive Self-Monitoring, Depersonalization.*

Results: At baseline, the subjects with binge eating disorder presented a significantly more negative body image (BUT and BDDE) with more intense feelings of shame and guilt (SSCV). At 6-month follow-up weight reduction was frequently, but not constantly, associated with less body uneasiness. Body dissatisfaction insignificantly increased at 1-year follow-up.

Discussion: Body image may not change in tandem with weight modification and weight loss is not always a sufficient solution of body image concerns in obese subjects (*vestigial body image*, according to Cash). It will be essential to know longer term effects of weight loss on body image and to analyse predictors of outcome.

FC12. Schizophrenia III

Chairs: A. Laurent (F), K. Hynek (CZ)

FC12.01

RISPERIDONE FOR CHRONIC SCHIZOPHRENIC PATIENTS ON DEPOT NEUROLEPTICS: A DETAILED CLINICAL AUDIT AND SWITCH STUDY

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Background: Data on the efficacy of novel antipsychotics in schizophrenia is largely a series of open multicentre and non randomised trials on schizophrenic subjects where representation remains unclear. The aims of the study were to (i) carry out a clinical audit of all patients on depot neuroleptics and from this identify those patients who would be eligible for a switch to oral risperidone (ii) to conduct a trial of Risperidone in all eligible and consenting patients.

Method: A detailed clinical audit of patients on depot neuroleptics was performed and included assessments of symptomatology, side-effects, quality of life, insight and attitude to medication. Eligible and consenting patients participated in a 6 month open trial of Risperidone and all consenters and non-consenters were followed up to 12 months assessing clinical status, side-effects and quality of life.

Results: Of 143 patients audited on depots in a service area of approx 100,000 population 69 were eligible for the trial and of these 33 consented to switch. 23 (76.7%) completed 6 months of treatment with Risperidone and all had a good outcome. Reasons for early dropout comprised non-compliance (4), adverse events (3), withdrawal of consent (2) and insufficient response (1). At 12 months 19 patients were still taking risperidone.

Conclusions: The study suggests that about 50% of consenting patients from amongst these with chronic schizophrenia receiving depot neuroleptics will do well when switched to oral Risperidone. Audit and 6 and 12 month follow-up data will be presented.

FC12.02

COULD THE SCHIZOTYPAL FEATURES EXPLAIN THE EQUIVOCAL FINDINGS OF THE WISCONSIN CARD SORTING TEST IN THE FIRST-DEGREE RELATIVES OF PATIENTS WITH SCHIZOPHRENIA?

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Even though the Wisconsin Card Sorting Test (WCST) has been proposed as an indicator of vulnerability to schizophrenia, no agreement can be found in the WCST studies of first-degree relatives of patients with schizophrenia. The aim of this study was to evaluate whether these equivocal findings could be reconciled if one takes into account the schizotypal features of the first-degree relatives.

Twenty four patients with schizophrenia, 49 of their first-degree relatives and 40 controls performed the computerised version of the WCST and were evaluated by the Social Anhedonia (SA), Physical Anhedonia (PA), Perceptual Aberration (PAS) and Magical Ideation (MI) scales. Non parametric Kruskall-Wallis and Mann-Whitney tests were used since the variables were not normally distributed.

The number of categories achieved was lower ($p < 0.03$) and the number of trials to complete the first category was higher ($p < 0.01$) in the schizophrenic than in the control group; none of the 8 WCST indexes studied was significantly different between the first-degree relative and control groups. The four scores of schizotypy were significantly higher in the patient group than in the control group (SA: $p < 0.01$; PA: $p = 0.0001$, PAS: $p < 0.0005$; MI: $p < 0.01$); in the first-degree relative group, the SA score tended to be higher ($p = 0.15$) than in the control group and the PA and PAS scores were intermediate between those of the patient and control groups. The number of perseverative responses (PR) and the number of perseverative errors (PE) were significantly higher in the subgroup of first-degree relatives whose SA score was 2SD above the mean of the control group ($p < 0.05$) than in the subgroup of the other first-degree relatives; a similar trend was found for the PA scale (PR: $p = 0.09$; PE: $p = 0.08$).

In conclusion, this study shows a link between the WCST performance and the negative dimension of schizotypy and supports the hypothesis that the lack of agreement between studies of first-degree relatives of patients with schizophrenia could be explained by discrepancies in schizotypal features.

FC12.03

RECENT DERMATOGLYPHIC STUDIES IN TWIN SAMPLES: FURTHER EVIDENCES FOR AN ENVIRONMENTAL RISK FACTOR IN SCHIZOPHRENIA

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Introduction: Examination of dermatoglyphic abnormalities as ridge dissociation (RD) and abnormal palmar flexion creases (APFC), may constitute enduring evidence of a prenatal insult occurred during the first or second trimester of intrauterine life. These measures can provide an indirect means to examine hypotheses relating abnormal CNS developmental processes to later psychoses.

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